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ABSTRACT

In response to a request from the chairman of the Congressional Select Committee on Aging, the General Accounting Office (GAO) investigated the potential effects of legislative proposals to provide catastrophic coverage to Medicare beneficiaries on beneficiaries' out-of-pocket health care expenses. The GAO reviewed GAO and other reports to identify types and amounts of out-of-pocket expenses, Medicare law and regulations to determine beneficiaries' out-of-pocket liability for covered services, and minimum coverage requirements for Medigap policies to determine how they affect costs. Fourteen catastrophic coverage bills were analyzed to determine how they would address the major types of catastrophic health care costs, and the financing mechanisms of the bills were compared. The GAO concluded that 9 of the 14 proposals reviewed would establish a catastrophic limit above which the beneficiary would no longer be liable for Medicare deductibles and coinsurance. It was concluded that, if enacted, these bills would represent an important step in increasing the health insurance coverage available to the elderly, but that significant gaps would remain. This report presents the GAO comparison of catastrophic health insurance proposals and looks at inpatient hospital care, nursing home care, home health care, Medicare Part B services, other medical services not covered by Medicare, catastrophic protection, and financing and costs. (NB)

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United States General Accounting Office

GAO

Briefing Report to the Chairman, Select Committee on Aging, House of Representatives

June 1987

MEDICARE

Comparison of Catastrophic Health Insurance Proposals

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GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-226390

June 19, 1987

The Honorable Edward R. Roybal
Chairman, Select Committee on Aging
House of Representatives

Dear Mr. Chairman:

This briefing report responds to your January 22, 1987, request concerning catastrophic health expenses and their effect on American families. As agreed with your office, this report focuses on legislative proposals to provide catastrophic coverage to Medicare beneficiaries. A future report will discuss the catastrophic health expenses of those under age 65.

BACKGROUND

Public programs financed two-thirds of the elderly's estimated $120 billion in personal health care expenditures in 1984. Medicare, which provides health insurance benefits for most individuals age 65 and older, pays about half of the elderly's total health care bill. Implemented in 1966 under title XVIII of the Social Security Act, Medicare comprises the Hospital Insurance Program (part A) and Supplementary Medical Insurance Program (part B). Medicare has a uniform eligibility and benefit structure and makes protection available without regard to income or assets.

Other major government sources of funds for the elderly's personal health care are Medicaid, a federal/state program of medical assistance to certain categories of low-income persons, and the Veterans Administration (VA), which provides care through its hospitals, outpatient clinics, and VA-operated and community nursing homes. In 1984, Medicaid paid about 13 percent of the elderly's health care bills; VA paid about 3 percent.

Even with government programs, the elderly face high out-of-pocket health care costs. According to a December 1986 report sponsored by the American Association of Retired Persons,[1] married couples over age 65 averaged about $3,000 in out-of-pocket health care costs in 1986.

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[1]ICF Incorporated, Medicaid's Role in Financing the Health Care of Older Women, December 1986, p. 36.

In November 1986, the Secretary of Health and Human Services (Otis R. Bowen, M.D.) reported[2] to the President on catastrophic illness expenses. Subsequently, the administration submitted a proposal to the Congress, and others have introduced bills to relieve the elderly from the burden of catastrophic health care expenses.

METHODOLOGY

To determine the potential effect of the various legislative proposals on Medicare beneficiaries' out-of-pocket health care expenses, we (1) reviewed GAO and other reports to identify the types and amounts of out-of-pocket expenses incurred by the elderly, (2) reviewed Medicare law and regulations to determine beneficiaries' out-of-pocket liability for covered services, (3) reviewed minimum coverage requirements for Medigap policies to determine how they affect out-of-pocket costs, (4) analyzed 14 catastrophic coverage bills introduced during the 100th Congress to determine how they would address the major types of catastrophic health care costs the elderly incur, and (5) compared the financing mechanisms of those bills.

RESULTS IN BRIEF

The catastrophic health insurance bills we reviewed either place an upper limit on beneficiary liability for Medicare deductibles and coinsurance or attempt to provide protection against some of the costs of services not currently covered by Medicare, such as long-term care and prescription drugs. The major effect of the first approach, which is adopted in both the House Committee on Ways and Means and Senate Committee on Finance approved bills, would be to make unnecessary a number of the coverage items in existing Medigap policies purchased by the elderly from private insurers. Beneficiaries, including lower income individuals who may not be able to afford Medigap premiums, would pay increased part B premiums. Medicare beneficiaries' income taxes would also be increased to finance the new coverage. According to the Congressional Budget Office, both bills would be budget neutral, and benefit costs paid out would range from $21.6 to $26.6 billion over the next 5 years. The Budget Office has not estimated the additional costs of the other bills that would expand services.

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[2]Department of Health and Human Services, Catastrophic Illness Expenses, Washington, D.C., November 1986.

Most of the proposals would essentially apply catastrophic dollar limits only to physician services and hospital care, which account for about 27 percent of the out-of-pocket costs incurred by the elderly.

Most of the proposals would leave the elderly at risk of high out-of-pocket costs because they

-- provide limited protection for nursing home and home health care for chronic conditions, the major source of out-of-pocket expenses;

-- exclude out-of-pocket expenditures for physician charges above the Medicare-approved payment; and

-- exclude out-of-pocket expenditures for services not covered by Medicare.

Because Medicare provides only minimal coverage of long-term care services for the chronically ill elderly, those needing such care would continue to be at risk for potential annual out-of-pocket costs for nursing home care (about $24,000 per year) and home health care (about $18,000 per year for daily visits).

Medigap policies primarily cover only the deductibles and coinsurance for Medicare-covered services rather than expand coverage to other services; therefore, neither they nor most of the catastrophic proposals would relieve the elderly from out-of-pocket costs for services not covered by Medicare. In addition, the elderly who incur such costs for noncovered services cannot apply them toward the catastrophic limits under the proposed bills.

According to the Bowen report, of the estimated 7 million beneficiaries who incurred from $2,000 to $4,999 in out-of-pocket costs for Medicare-covered services in 1983, 32.4 percent of those costs were for physician charges above the Medicare-approved rate. Similarly, of the estimated 1 million beneficiaries incurring $5,000 or more in out-of-pocket costs for Medicare-covered services, 21.9 percent of those costs were for physician charges above the Medicare-approved rate. Most of the catastrophic proposals would not relieve Medicare beneficiaries of these out-of-pocket costs. Although the majority of Medicare beneficiaries have Medigap policies to pay the coinsurance for part B services, Medigap policies generally will not pay for charges above the Medicare-approved rate.

Of the 14 proposals we reviewed, 9 would establish a catastrophic limit above which the beneficiary would no longer be liable for Medicare deductibles and coinsurance. This is the standard method of providing catastrophic coverage in health insurance programs. Of course, having a fixed dollar catastrophic limit affects beneficiaries in different ways; that is, lower income beneficiaries would have to spend a higher percentage of their income on health care before they reached the limit than would higher income beneficiaries. Both of the legislative proposals approved by the House and Senate committees have financing mechanisms that relate the amount beneficiaries pay for catastrophic coverage to their incomes.

These bills, if enacted, would represent an important step in increasing the health insurance coverage available to the elderly, but as discussed above, significant gaps will remain. Providing further relief to those elderly who incur high out-of-pocket health care costs would obviously increase Medicare payments. The bills that would offer more extensive catastrophic protection propose a variety of financing mechanisms to spread the costs of catastrophic illnesses over either all Medicare beneficiaries or all taxpayers, and are intended to be budget neutral.

As requested by your office, we did not obtain agency comments on this briefing report. Unless you publicly announce its contents earlier, we plan no further distribution until 30 days from the report's issue date. At that time, we will send copies to other congressional committees having jurisdiction over the matters discussed in the report, the Secretary of Health and Human Services, and other interested parties.

If you have any questions, please call me on 275-6195.

Sincerely yours,

Michael Zimmerman
Senior Associate Director

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Abbreviations

AARP	American Association of Retired Persons
GAO	General Accounting Office
ICF	intermediate care facility
SNF	skilled nursing facility
VA	Veterans Administration

MEDICARE: COMPARISON OF CATASTROPHIC HEALTH INSURANCE PROPOSALS

INTRODUCTION

In September 1986 we reported[1] that spending for personal health care for the elderly almost tripled between 1977 and 1984, increasing from $43 billion to a projected $120 billion. By 1984, persons 65 and over accounted for one-third of all personal health care expenditures nationally. Public sources--Medicare, Medicaid, and the Veterans Administration (VA)--financed about two-thirds of the 1984 personal health care expenditures of the elderly.

Medicare

Medicare is a federal program (authorized effective on July 1, 1966, by title XVIII of the Social Security Act) that assists most of the elderly and some disabled people in paying for their health care. The program provides two basic forms of protection:

-- Part A, Hospital Insurance, which is financed primarily by Social Security payroll taxes, covers inpatient hospital services, posthospital care in skilled nursing facilities (SNFs), hospice care, and care provided in patients' homes. In fiscal year 1985, Medicare part A covered 30.6 million enrollees, and benefits amounted to about $46 billion. About $43 billion (94 percent) of part A expenditures were for inpatient hospital services.

-- Part B, Supplementary Medical Insurance, which is a voluntary program financed by enrollee premiums (25 percent of total costs) and federal general revenues, covers physician services and a variety of other health care services, such as laboratory and outpatient hospital services. In fiscal year 1985, Medicare part B covered 30 million enrollees, and benefits totaled about $21.9 billion.

Although the scope and coverage of medical services under Medicare is broad, it requires considerable beneficiary cost sharing, and there is no catastrophic limit on medical expenses paid by the beneficiary. Additionally, some health care expenses are not covered at all, such as outpatient drugs; vision, hearing, and dental care; and care provided in intermediate or custodial care facilities.

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[1]An Aging Society: Meeting the Needs of the Elderly While Responding to Rising Federal Costs (GAO/HRD-86-135, Sept. 30, 1986).

Medicaid

Medicaid is a grant-in-aid program under which the federal government pays from 50 to 78 percent of state costs for medical services provided to low-income people unable to pay for their care. The program, authorized by title XIX of the Social Security Act, began on January 1, 1966.

Within broad federal guidelines, each state designs and administers its own Medicaid program. We reported in May 1987[2] that this results in significant interstate variations in eligibility requirements and benefits provided.

Medicaid regulations require participating states to cover 10 basic services for all categorically needy recipients, including inpatient and outpatient hospital services, laboratory and X-ray services, services in a SNF, home health services, and physician's services. States can also offer any mix of specified optional services, such as home and community-based services; services in an intermediate care facility (ICF); and prescribed drugs, dentures, and eyeglasses.

In recent years, the number of Medicaid recipients age 65 and over was estimated to range from 3.5 to 4 million, most of whom were also covered by Medicare. In 1984, state and federal Medicaid expenditures for the elderly totaled an estimated $15.3 billion, primarily for nursing home care.[3]

Veterans Administration

VA, authorized under title 38 of the U.S. Code, operates the largest health care delivery system in the United States. In addition to providing care in VA hospitals, outpatient clinics, nursing homes, and domiciliaries, VA awards contracts and grants to provide health care services in non-VA hospitals, community nursing homes, and state veterans' homes. In 1984, VA had about $3.3 billion in health expenditures for the elderly.

Before 1986, any honorably discharged veteran 65 or over was eligible for free care at VA facilities on a space-available basis. In 1986, the Comprehensive Omnibus Budget Reconciliation Act of 1985 eliminated the separate basis of eligibility for

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[2]Medicaid: Interstate Variations in Benefits and Expenditures (GAO/HRD-87-67BR, May 4, 1987).

[3]Daniel R. Waldo and Helen C. Lazenby, "Demographic Characteristics and Health Care Use and Expenditures by the Aged in the U.S.: 1977-1984," Health Care Financing Review, Vol. 6, No. 1, Fall 1984, pp. 23-24.

veterans 65 and older and established three categories of eligibility based on income for veterans with no service-connected disabilities.

Medigap

The majority of elderly people purchase some type of private supplemental insurance (commonly called Medigap insurance) to cover all or part of the deductible and coinsurance amounts not covered by Medicare. However, the percentage of the population with Medigap coverage increases as family income increases (see figure 1). About 44 percent of the elderly with family incomes below $5,000 have Medigap coverage compared to 87 percent of those with incomes of $25,000 and over. More importantly, about 30 percent of those with incomes below $9,000 have neither Medicaid nor Medigap coverage, placing them at the greatest risk from high out-of-pocket costs.

Section 1882 of the Social Security Act, added by Public Law 96-265, June 9, 1980, established standards for Medigap policies requiring that they provide at least a minimum level of coverage and include certain provisions. The law also set minimum expected levels of benefit payments--called loss ratios. Medigap policies sold to individuals must have an anticipated return of benefits to policyholders of at least 60 percent of the premiums collected, and 75 percent for policies sold to groups.

In October 1986 we reported[4] that Medigap policies sold by commercial insurers that had more than $50 million in premiums and Blue Cross/Blue Shield plans generally met the loss ratio requirements of section 1882, i.e., that about 60 cents of every premium dollar be returned as benefits or added to reserves. However, over 60 percent of the commercial insurance policies with premiums under $50 million in 1984 did not meet these requirements.

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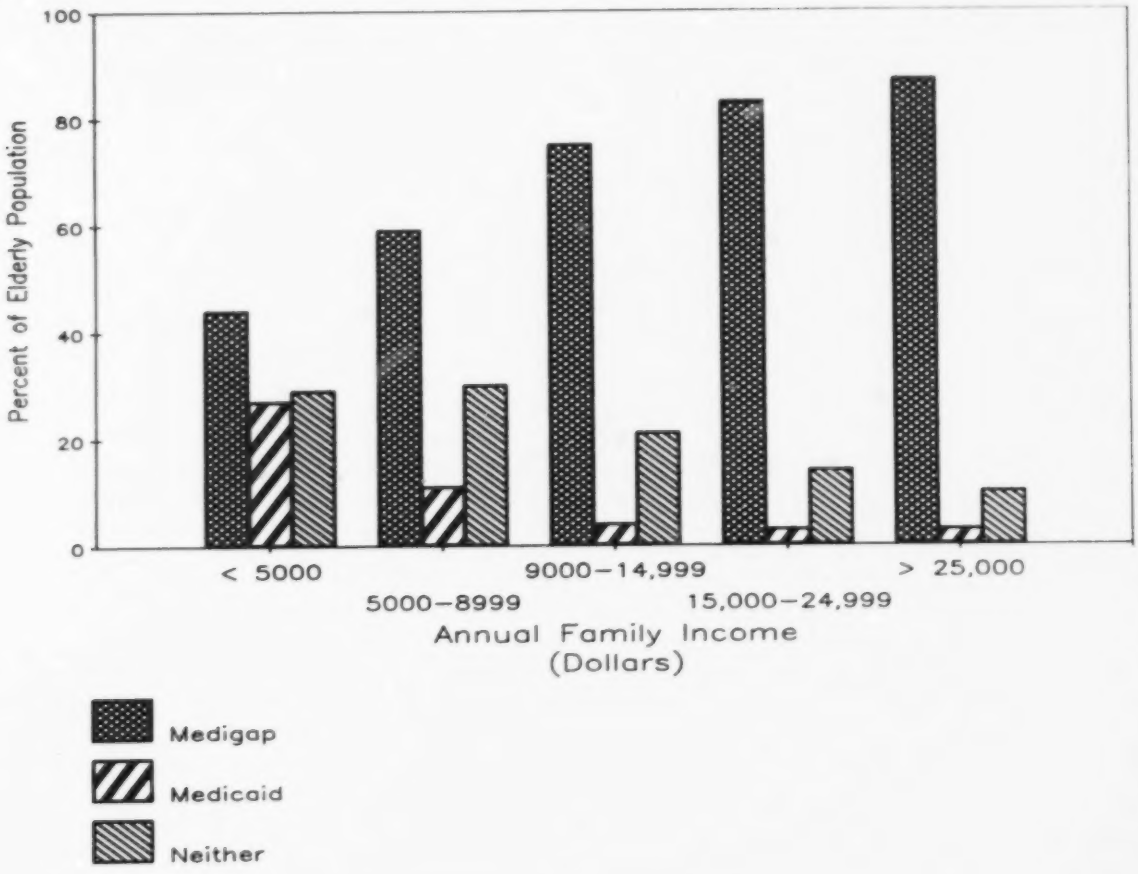
[4]Medigap Insurance: Law Has Increased Protection Against Substandard and Overpriced Policies (GAO/HRD-87-8, Oct. 17, 1986).

Figure 1: Medigap Coverage for the Elderly, by Family Income
(1986)



Source: Congressional Budget Office.

Out-of-Pocket Costs

"Catastrophic" health care expense may be defined in terms of out-of-pocket expenses relative to income or of an absolute dollar amount (such as the $500 to $2,000 caps proposed by the various bills). In a November 1986 report on catastrophic illness expenses,[5] the Secretary of Health and Human Services described catastrophic illness expenses as those that cannot be borne by individuals and families without having to significantly

[5]Department of Health and Human Services, Catastrophic Illness Expenses, Washington, D.C., November 1986, p. 15.

change their life style or drastically modify their expectations of living standards in the future. We have used the term catastrophic in this report in describing examples of health care expenses that may or may not be considered catastrophic depending on the definition used.

According to a December 1986 report sponsored by the American Association of Retired Persons (AARP),[6] the out-of-pocket health care expenditures for married couples over age 65 averaged about $3,000 in 1986, including health insurance premiums. According to the Congressional Budget Office,[7] the amounts different persons pay in out-of-pocket costs differ by orders of magnitude. The distribution of copayments, for example, would be very uneven in 1989 under current law, with 30 percent of Medicare enrollees incurring little or no costs, while 0.5 percent with long or multiple hospital stays would incur average out-of-pocket costs of about $8,000.

According to the Bowen report, nursing home expenditures accounted for 41.6 percent of the elderly's out-of-pocket expenditures; physician services, 21.4 percent; hospital care, 5.6 percent; and other care, 31.3 percent (including services not covered or partly covered by insurance, and long-term care services other than nursing home care).

The sources of the elderly's out-of-pocket costs vary depending on the total out-of-pocket expenses incurred. Rice and Gabel[8] reported that for the elderly subject to very high financial liabilities (more than $2,000), nursing home care is the overwhelming cause (see figure 2).[9] On the other hand, the elderly with relatively low out-of-pocket costs spent their money primarily on physician, drug, and dental services. Specifically, 95 percent of the out-of-pocket costs for those spending $500 or less were attributed to those three types of services.

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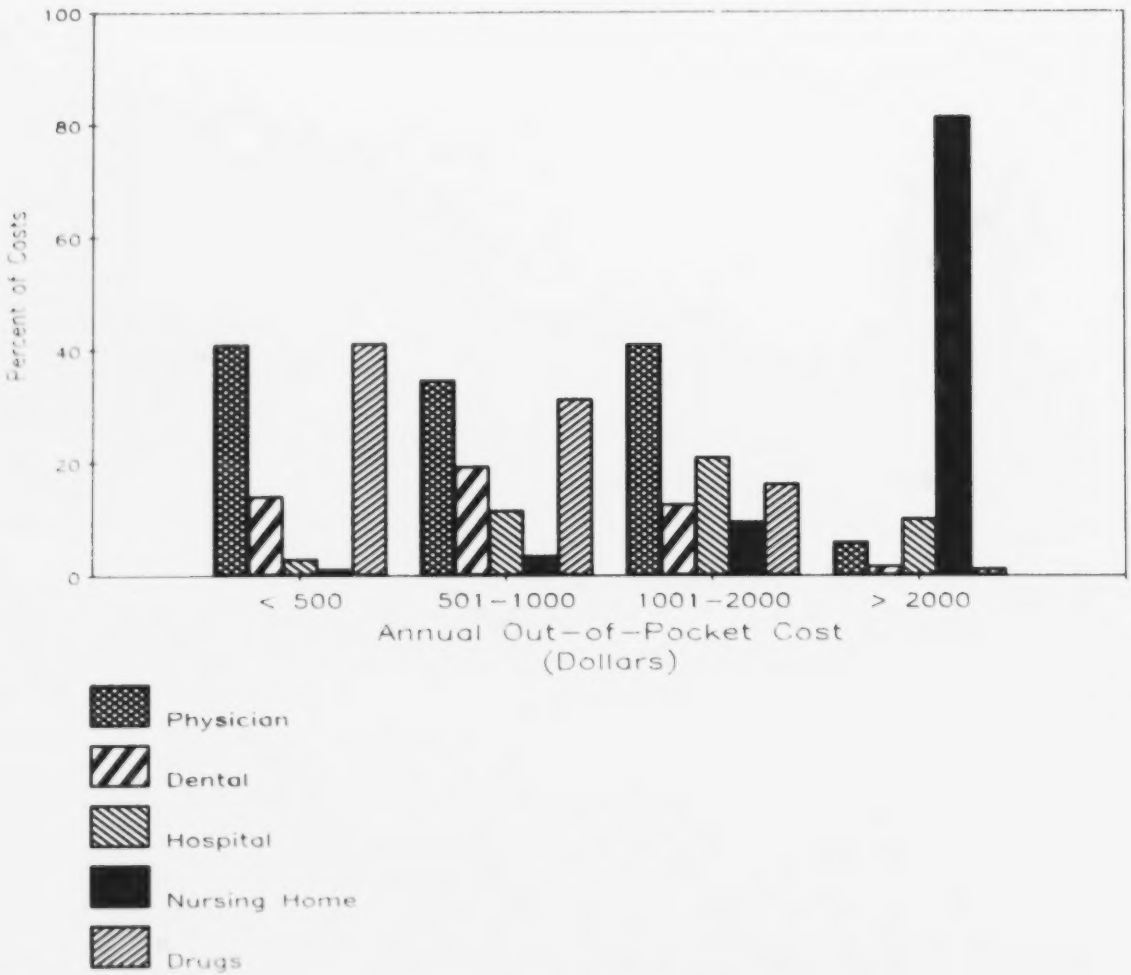
[6]ICF Incorporated, Medicaid's Role in Financing the Health Care of Older Women, Washington, D.C., December 1986, p. 39.

[7]U.S. Congressional Budget Office, A Comparison of Selected Catastrophic Bills, Washington, D.C., May 27, 1987, p. 12.

[8]Thomas Rice and Jon Gabel, "Protecting the Elderly Against High Health Care Costs," Health Affairs, Vol. 5, No. 3, Fall 1986, p. 16.

[9]Their analysis was based on data from the 1980 National Medical Care Utilization and Expenditure Survey and the 1976-77 National Nursing Home Survey, projected to 1980, the most recent national data available.

Figure 2: Out-of-Pocket Costs for the Elderly, by Type of Service (1986)

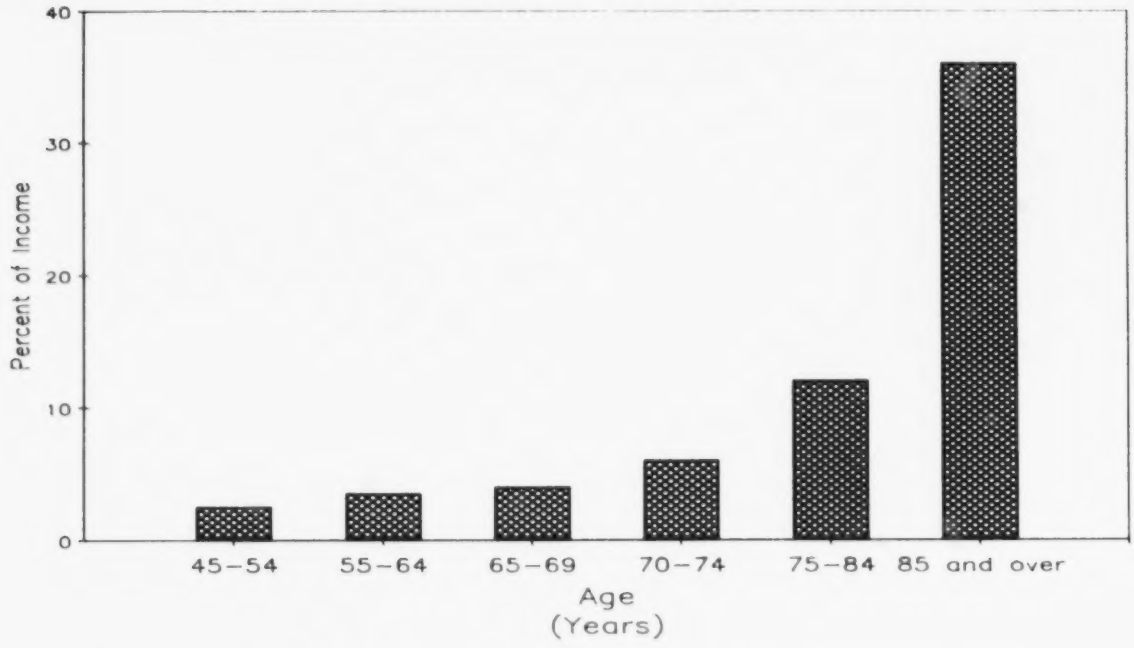


Source: Thomas Rice and Jon Gabel, "Protecting the Elderly Against High Health Care Costs," Health Affairs, Vol. 5, No. 3, Fall 1986, p. 16.

The AARP report also showed that out-of-pocket expenditures as a percentage of income increase with age (see figure 3). For example, the report notes that out-of-pocket expenditures

(excluding health insurance premiums) will average about 8.3 percent of household income for all elderly woman households[10] compared to about 2.8 percent among the 45- to 64-year-old group. Particularly at risk are the elderly 85 and over. Of this elderly population, nearly 70 percent are women who spend an average of over 35 percent of their income on medical expenses.

Figure 3: Out-of-Pocket Health Expenditures for All Older Women as a Percentage of Income, by Age (1986)



Source: ICF Incorporated, Medicaid's Role in Financing the Health Care of Older Women, Washington, D.C., Dec. 1986, p. 44.

Objective, Scope, and Methodology

The Chairman of the House Select Committee on Aging asked us to provide information on catastrophic health expenses and their effect on American families. During later discussions with the Chairman's office, we agreed to focus our work on 14 legislative proposals introduced during the 100th Congress concerning the catastrophic health expenses of Medicare beneficiaries and to

[10]Single women 65 or older and married couples with a woman 65 or older.

analyze the potential effects of the proposals on out-of-pocket costs. Rather than evaluating every provision of the legislative proposals, we concentrated on the provisions that would have the greatest impact on catastrophic expenses.

The bills reviewed and their primary sponsors were:

S. 1127--Bentsen (referred on May 5, 1987, to Senate Committee on Finance).
H.R. 2470--Stark (jointly referred on May 19, 1987, to House Committees on Energy and Commerce and on Ways and Means).
S. 592--Dole (administration bill).
H.R. 1245--Michel (administration bill).
S. 210--Kennedy.
S. 454--Sasser.
S. 754--Dole.
H.R. 65--Pepper.
H.R. 200--Roybal.
H.R. 784--Bonker.
H.R. 1182--Regula.
H.R. 1280--Stark.
H.R. 1281--Stark.
H.R. 1930--Roybal.

(Although we discuss H.R. 1280 (which addresses part A) and H.R. 1281 (which addresses part B) separately, they comprise a legislative package for catastrophic protection. H.R. 1280 and H.R. 1281, when combined, are very similar to H.R. 2470.)

To determine the potential effect of the legislative proposals on Medicare beneficiaries' out-of-pocket health care expenses, we (1) reviewed GAO and other reports to identify the types and amounts of out-of-pocket expenses incurred by the elderly, (2) reviewed Medicare laws and regulations to determine beneficiaries' out-of-pocket liability for covered services, (3) reviewed minimum coverage requirements for Medigap policies to determine how they affect out-of-pocket costs, (4) evaluated 14 catastrophic coverage bills to determine how they would address the major types of catastrophic health care costs the elderly incur, and (5) compared the bills' financing mechanisms.

Our work was done between March and June 1987.

COMPARISON OF CATASTROPHIC INSURANCE PROPOSALS

The following sections compare the catastrophic insurance proposals to the current coverage available from the Medicare program and Medigap insurance. Our analysis is presented in five tables that show the out-of-pocket liability for Medicare beneficiaries currently and under the pending bills for (1) inpatient hospital services, (2) nursing home care, (3) home health care, (4) Medicare part B services, and (5) services not

covered by Medicare. In a sixth table, we compare the catastrophic expense protection limits established in the bills. Finally, we discuss the changes in financing proposed in the bills reported out of the Senate Committee on Finance and the House Committee on Ways and Means, and those proposed by the administration.

Table 1:
Medicare Beneficiary's Liability for Part A Inpatient Hospital Expenses

	Deductible per Spell of illness	Deductible per Year	Daily coinsurance 61st to 90th day	Daily coinsurance Lifetime reserve days (60)	Days in excess of lifetime reserve	Over 190 lifetime psychiatric days	Blood deductible per Spell of illness	Blood deductible per Year
Current Medicare law	$520		$130	$260	All	All	1st 3 pints	
Medigap, maximum out-of-pocket costs	$520		None	None	10%[a]	All	None	None
Bill #								
S. 1127		$520	$130	$260	All	All		1st 3 pints
H.R. 2470		$520	None	None	None	All	1st 3 pints	
S. 592[b]	$520[c]		None	None	None	All	1st 3 pints	
H.R. 1245[b]	$520[c]		None	None	None	All	1st 3 pints	
S. 210	$520	[d]	None	None	None	All	1st 3 pints	
S. 454	None	None	None	None	None	All	None	None
S. 754		$520	None	None	None	All	None	None
H.R. 65	None	None	None	None	None	All	None	None
H.R. 200	None	None	20%[e]	20%	20%	None	None	None
H.R. 784	$520		None	None	None	All	1st 3 pints	
H.R. 1182	$520[c]		None	None	None	All	1st 3 pints	
H.R. 1280[f]		$520	None	None	None	All		1st 3 pints
H.R. 1281[f]	$520		$130	$260	All	All	1st 3 pints	
H.R. 1930		$520	None	None	None	All		1st 3 pints

[a]Medigap policies pay at least 90% of covered charges up to 365 days after the insured has exhausted his or her Medicare benefits.

[b]Administration bill.

[c]No more than two inpatient hospital deductibles per year would count toward the catastrophic limit.

[d]The bill would pay for the first 10 days of hospital care after the second hospitalization in any calendar year.

[e]A $500 cap would be placed on beneficiaries' coinsurance payments.

[f]Although we discuss the two bills separately, H.R. 1280 (which addresses part A) and H.R. 1281 (which addresses part B) comprise a legislative package for catastrophic protection. H.R. 1280 and H.R. 1281, when combined, are very similar to H.R. 2470.

INPATIENT HOSPITAL CARE

Definitions

Inpatient hospital care includes room and board; regular nursing services; special care unit services, such as intensive care or coronary care; drugs furnished by the hospital; blood transfusions; laboratory tests; X-rays and other radiology services; medical supplies, such as surgical dressings; use of appliances, such as a wheelchair; operating and recovery room costs, including anesthesia services; rehabilitation services, such as physical or speech therapy; and psychiatric care.

Deductibles are the amount of covered charges that a beneficiary must pay before his or her health plan pays any benefits. Deductibles may apply either to a calendar year or on a per admission basis.

Coinsurance is the fixed percentage or amount of covered medical charges that the beneficiary must pay.

Medicare Coverage

Medicare part A, hospital insurance, covers inpatient hospital services on the basis of a "spell of illness." For any benefit period, part A pays for all covered services for the first 60 days of inpatient hospital care except for the inpatient deductible ($520 in 1987) and the first three pints of blood used. For the next 30 days, the beneficiary is responsible for coinsurance equal to one-quarter of the deductible amount per day ($130 in 1987). Every person enrolled in part A also has a 60-day, nonrenewable, lifetime reserve for inpatient hospital care that can be drawn from if more than 90 days are needed in a benefit period. When using the reserve days, the beneficiary is responsible for coinsurance equal to one-half of the deductible amount per day ($260 in 1987). Medicare coverage for care in a psychiatric hospital is limited to 190 days during a beneficiary's lifetime.

Out-of-Pocket Expenses

The Bowen report states that Medicare pays for more than 90 percent of expenditures for services covered under part A (which covers inpatient hospital and skilled nursing care). This left net beneficiary liabilities of about $2.9 billion in 1983.

About 65 percent of Medicare beneficiaries purchase Medigap policies. Minimum standards for Medigap policies require coverage of Medicare's part A blood deductible and coinsurance amounts for the 61st through 90th day and while the beneficiary uses his or her lifetime reserve days. Medigap policies must also cover 90 percent of covered hospital inpatient expenses for

a lifetime maximum of up to 365 days after the insured has exhausted his or her Medicare benefits.

However, for the approximately 35 percent of Medicare beneficiaries without Medigap coverage--primarily those with lower incomes--beneficiaries are responsible for Medicare inpatient deductibles, blood deductibles, and coinsurance for hospital stays over 60 days in duration. For example, for a beneficiary who is hospitalized once during a year for 90 days, the out-of-pocket expense for inpatient services would be $4,420, consisting of the $520 deductible and daily coinsurance of $130 for the 61st to the 90th day. If this beneficiary stayed longer, coinsurance would increase to $260 for each day and the beneficiary would be using his or her lifetime reserve days. A stay of 10 more days (100 days total) would increase the total out-of-pocket expenses to $7,020. However, if this beneficiary had a Medigap policy providing the minimum required coverage, his or her out-of-pocket expenses for either the 90- or the 100-day stay would be $520 (the Medicare part A deductible). Even with the minimum coverage required under Medigap regulations, beneficiaries would generally incur a deductible of $520 for every new spell of illness. For example, in fiscal year 1984, approximately 8,200 beneficiaries were hospitalized during four spells of illness. Using the current deductible of $520, out-of-pocket expenses for four spells of illness would amount to $2,080 just for the Medicare part A inpatient deductibles. In addition, the beneficiary would be liable for the cost or replacement of the first three pints of blood received during each spell of illness.

Legislative Proposals

The 14 legislative proposals we reviewed used various methods for reducing beneficiary out-of-pocket expenses for hospital inpatient care.

Medicare inpatient coinsurance--H.R. 200 proposes changing the coinsurance to 20 percent with a $500 cap on out-of-pocket expenses. S. 1127 and H.R. 1281 propose no change to coinsurance but set a cap on overall out-of-pocket expenses. The remaining 11 bills propose eliminating the beneficiary's coinsurance.

Medicare inpatient deductible--Five bills (S. 1127, H.R. 2470, S. 754, H.R. 1280, and H.R. 1930) propose limiting the Medicare deductible to one per year rather than for each spell of illness, and three (H.R. 65, H.R. 200, and S. 454) propose eliminating the Medicare deductible. The other six bills would retain the concept of applying the Medicare deductible to each spell of illness, but three (S. 592, H.R. 1245 and H.R. 1182) would limit the number of deductibles per year that can be applied toward the catastrophic cap.

Reserve days--Twelve bills (all except S. 1127 and H.R. 1281) propose eliminating the 60-day cap on lifetime reserve days. Of these, H.R. 200 proposes applying a 20-percent coinsurance to additional days. Under S. 1127 and H.R. 1281, the beneficiary would continue to be liable for all charges incurred for hospital stays of over 90 days once they have used their lifetime reserve days.

Psychiatric days--H.R. 200 proposes eliminating the 190-day limit on inpatient care in a psychiatric hospital. Under the other 13 bills, the beneficiary would continue to be liable for all charges beyond 190 days of inpatient psychiatric care.

Blood deductible--Four bills (S. 454, S. 754, H.R. 65, and H.R. 200) propose eliminating the part A blood deductible of the first three pints for each spell of illness. Three bills (S. 1127, H.R. 1280, and H.R. 1930) propose applying the blood deductible once per year instead of for each spell of illness. Under the other seven bills, the beneficiary would continue to pay for the first three pints of blood for each spell of illness.

GAO Comments

By reducing or eliminating coinsurance for hospital care, the legislative proposals would significantly reduce Medicare beneficiaries' out-of-pocket costs for hospital care. Also, they may be of particular benefit to low-income elderly who cannot afford Medigap coverage and are not eligible for Medicaid by enabling them to obtain needed coverage. Since the proposals would, to a large extent, supersede current Medigap coverage, Medigap policies might be restructured to cover other services not provided under Medicare, such as dental care and hearing aids.

Table 2:
Medicare Beneficiary's Liability for Nursing Home Services

	Skilled nursing care daily coinsurance per spell of illness				
	1st to 20th day	21st to 100th day	Over 100 days	Intermediate care	Custodial care
Current Medicare law	None	$65	All	All	All
Medigap, maximum out-of-pocket costs	None	$65	All	All[a]	All[a]
Bill #					
S. 1127	None[b]	None	All[c]	All	All
H.R. 2470	$24 daily for 1st 7 days	None	[d]	All	All
S. 592[e]	None[f]	None[f]	All[f]	All	All
H.R. 1245[e]	None[f]	None[f]	All[f]	All	All
S. 210	None	$65[g]	All	All	All
S. 454	None[h]	None[h]	None[h]	None	None[i]
S. 754	None	None	All	All	All
H.R. 65	None[h]	None[h]	None[h]	None	None[i]
H.R. 200	20%	20%	20%[j]	20%	25%
H.R. 784	None	$65	All	All	All
H.R. 1182	None	None	All	All	All
H.R. 1280[k]	$24 daily for 1st 7 days	None	[d]	All	All
H.R. 1281[k]	None	$65	All	All	All
H.R. 1930	$24 daily for 1st 7 days	None	[d]	All	All

[a]Medigap usually does not cover services that are not covered by Medicare.

[b]Individuals covered under part A and part B have to pay for 1st 10 days in a SNF.

[c]After individuals with part A and part B coverage pay for the first 10 days in a SNF, their liability for full cost does not begin until after the 150th day. Individuals covered under part A only are liable for full costs after the 100th day.

[d]Extended care services would be increased to 150 days per year.

[e]Administration bill.

[f]Administration bills eliminate coinsurance, but provide a maximum of 100 days skilled nursing care per year, rather than per spell of illness.

[g]Provides payment for reasonable charges for not more than 100 days in a calendar year after the catastrophic limit is reached.

[h]The requirement that skilled nursing care be posthospital would be eliminated.

[i]Adult day care and home and community-based services are specifically included.

[j]The bill introduces unlimited days of skilled nursing care.

[k]Although we discuss the two bills separately, H.R. 1280 (which addresses part A) and H.R. 1281 (which addresses part B) comprise a legislative package for catastrophic protection. H.R. 1280 and H.R. 1281, when combined, are very similar to H.R. 2470.

NURSING HOME CARE

Definitions

Skilled nursing facilities provide skilled nursing and rehabilitative services to patients on a daily basis under the orders of a physician.

Intermediate care facilities provide health-related care and services to individuals who do not require the degree of care and treatment that is provided in a hospital or SNF but who, because of their mental or physical condition, require medical care in addition to room and board.

Custodial care facilities provide assistance in requirements of daily living, such as eating and bathing, which can be provided by persons without medical skills.

Medicare Coverage

Medicare's coverage of nursing home care is applicable to acute rather than chronic types of illness; therefore, Medicare will help pay for the first 100 days of skilled nursing home care after a hospitalization. Medicare will pay for the 1st to the 20th day of care, beginning with the 21st day the beneficiary has to pay the coinsurance rate of $65 per day through the 100th day. The beneficiary has liability for all expenses starting with the 101st day of care.

Medicare does not cover care provided in ICFs or custodial care facilities.

Out-of-Pocket Expenses

The beneficiary has liability for all expenses incurred in ICFs and custodial care facilities and $65 per day for care in SNFs for stays from 21 to 100 days and all expenses for stays over 100 days. Long-term care expenses can become catastrophic in a relatively short time since nursing home expenses average about $2,100[11] or more a month. Costs associated with long-term care over an extended period can wipe out the savings of a lifetime, and very few elderly people have financial protection for such expenses. A Massachusetts-based study by Harvard Medical School and Massachusetts Blue Cross/Blue Shield reported that 63 percent of elderly persons living alone will impoverish themselves in only 13 weeks in a nursing home. For elderly

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[11] An Aging Society: Meeting the Needs of the Elderly While Responding to Rising Federal Costs (GAO/HRD-86-135, Sept. 30, 1986), p. 57.

married couples, 37 percent will become impoverished within 13 weeks if one spouse requires nursing home care.[12]

According to a December 1986 report[13] sponsored by AARP, about 1.9 million persons over age 45 are estimated to be in nursing homes in 1986, including about 23 percent of the population 85 and older. Of this elderly population, nearly 70 percent are women who spend an average of over 35 percent of their income on medical expenses, primarily because of the high cost of nursing home care and the limited Medicare and Medigap coverage.

Legislative Proposals

The 14 bills would expand Medicare nursing home coverage in three primary ways--reducing or eliminating coinsurance, extending days of coverage, or expanding coverage to include care in ICFs and custodial care facilities.

Coinsurance--Five bills (S. 1127, H.R. 2470, H.R. 200, H.R. 1280, and H.R. 1930) would impose coinsurance during a portion of the first 20 days of a SNF stay. Ten bills would eliminate the $65 coinsurance for SNF stays of 21 to 100 days.

Extending days of coverage--S. 1127, H.R. 2470, H.R. 1280, and H.R. 1930 would extend Medicare SNF coverage from 100 to 150 days with no coinsurance, while H.R. 200 would remove the 100-day cap but impose coinsurance for stays in excess of 100 days.

Intermediate and custodial care--Three bills (S. 454, H.R. 65, and H.R. 200) would extend Medicare coverage to include services provided in ICFs and custodial care facilities.

GAO Comments

The effect of the proposed change in the coinsurance and benefit period for SNF care on the elderly's out-of-pocket costs may be limited because of other provisions of the Medicare law governing payment for SNF care. Many SNF patients lose their Medicare coverage because they do not qualify as requiring daily skilled care or therapy that will lead to a patient's

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[12]House of Representatives, Select Committee on Aging. Hearing on The 20th Anniversary of Medicare and Medicaid: Americans Still at Risk. Washington, D.C., July 30, 1985, p. 35.

[13]ICF Incorporated, Medicaid's Role in Financing the Health Care of Older Women, Washington, D.C., December 1986, p. 22.

rehabilitation. According to Rice and Gabel,[14] Medicare SNF coverage lasted an average of 28 days in 1977, while the average stay lasted twice as long. They said that the "cutoffs" occurred because patients soon reached their "rehabilitation potential" and subsequently needed "maintenance therapy," which is not considered skilled care. Eliminating Medicare coinsurance or extending days of coverage would, therefore, not benefit such patients.

More significantly, the elderly would remain at risk for out-of-pocket nursing home costs for intermediate or custodial care under most proposals. Adding long-term nursing home coverage to the Medicare program would, however, be costly since such services accounted for about $18 billion in out-of-pocket costs in 1984, according to the Bowen report.

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[14]Thomas Rice and Jon Gabel, "Protecting the Elderly Against High Health Care Costs," Health Affairs, Vol. 5, No. 3, Fall 1986, p. 8.

Table 3:
Medicare Beneficiary's Liability for Home Health Services

	Not skilled or not part time	Not confined to home	Not Medicare certified
Current Medicare law	All	All	All
Medigap, maximum out-of-pocket costs	All	All	All
Bill #			
S. 1127	All	All	All
H.R. 2470	All	All	All
S. 592[b]	All	All	All
H.R. 1245[b]	All	All	All
S. 210	All	All	All
S. 454	None	All	All
S. 754	All[c]	All	All
H.R. 65	None	All	All
H.R. 200	[d]	All	All
H.R. 784	All	All	All
H.R. 1182	All	All	All
H.R. 1280[a]	All	All	All
H.R. 1281[a]	All	All	All
H.R. 1930	All[e]	All	All

[a]Although we discuss the two bills separately, H.R. 1280 (which addresses part A) and H.R. 1281 (which addresses part B) comprise a legislative package for catastrophic protection. H.R. 1280 and H.R. 1281, when combined, are very similar to H.R. 2470.

[b]Administration bill.

[c]Nursing care and home health aide services provided for 21 days with physician certification.

[d]Services of a homemaker/home health aide when essential to the individual being maintained in an individual's home.

[e]Includes rehabilitative and short-term personal support services to prevent institutionalization.

HOME HEALTH CARE

Definition

Home health care is medically supervised care and treatment provided by nurses and aides in the patient's home. It includes such services as skilled nursing care, dressing changes, injections, monitoring of vital signs, physical therapy, prescription drugs and medications, nutrition services, medical social work, and medical appliances or equipment.

Medicare Coverage

Medicare home health benefits are, by law, oriented toward skilled nursing care. They were not designed to provide coverage for care related to helping with daily living needs unless the patient also required skilled nursing care or physical or speech therapy. Medicare home health services include

-- part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

-- physical, occupational, or speech therapy;

-- medical social services to help patients and their families adjust to social and emotional conditions related to the patients' health problems;

-- part-time or intermittent home health aide services;[15] and

-- certain medical supplies and appliances.

To qualify for Medicare home health care, a person must be confined to his or her residence (homebound), be under a physician's care, and need part-time or intermittent skilled nursing care and/or physical or speech therapy. The services must be furnished by a Medicare-approved home health agency under a plan of care prescribed and periodically reviewed by a physician. There are no deductibles or coinsurance for Medicare-covered home health services.

Out-of-Pocket Expenses

Because Medicare pays the total cost of covered home health services, the elderly incur out-of-pocket expenses solely for

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[15]Home health aides, among other things, help patients bathe, groom, get into and out of bed, use the bathroom, take self-administered medications, and exercise.

noncovered services. We reported in December 1986[16] that the Medicare benefit was not designed to meet all of the elderly's home care needs. Medicare beneficiaries who are not homebound or do not require skilled nursing care on a part-time or intermittent basis must find needed assistance with their personal care needs (activities of daily living) and homemaker needs (instrumental activities of daily living) from family, friends, and other paid or unpaid caregivers. Similarly, beneficiaries whose home care needs exceed the limits of Medicare coverage must find other sources of support once their Medicare coverage ends.

Chronically ill beneficiaries who do not qualify for the limited home health benefit under Medicare can incur significant out-of-pocket costs for such assistance. Our December 1986 report showed that the average cost of a home health visit in 1982 was about $36. The Health Care Financing Administration reported that charges by Medicare home health agencies averaged $49 per visit in 1985. Based on that cost, the elderly requiring home health services could incur annual out-of-pocket costs for home health care from about $2,500 for visits once a week to about $18,000 for daily visits.

In our December 1986 report, we analyzed data from the 1982 National Long-Term Care Survey and found that of the 3.2 million elderly with one or more limitations in their activities of daily living, about 168,000 (5 percent) were not receiving all of the assistance they needed with activities of daily living, and another 1.1 million (36 percent) needed more assistance with instrumental activities of daily living. We believe the high out-of-pocket costs of such assistance may contribute to the level of unmet need for home care assistance.

Legislative Proposals

Most of the legislative proposals reviewed would not affect out-of-pocket costs for home health services because these costs are incurred solely for noncovered services. However, four bills would clarify, and probably expand, Medicare coverage of home health services:

-- S. 754 and S. 1127 would allow nursing care and home health aide services to be provided on a daily basis (with one or more visits per day) for up to 21 days with a physician's certification of the need for such services.

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[16]Medicare: Need to Strengthen Home Health Care Payment Controls and Address Unmet Needs (GAO/HRD-87-9, Dec. 2, 1986).

-- H.R. 65 would remove the requirement that an individual need skilled care on an intermittent basis in order to qualify for Medicare coverage.

-- H.R. 1930 would clarify the requirements that an individual need skilled nursing care on an intermittent basis and be homebound. It would consider, as intermittent, nursing care that is furnished on a consecutive, daily basis if furnished for less than 90 consecutive days during any year and, if certified by a physician because of exceptional circumstances, for a longer consecutive period during a year. An individual would be considered to be "confined to his home" if he has a normal inability to leave home and leaving home requires a considerable and taxing effort. The bill also states that an individual can still be considered confined to his home despite occasional absences for medical or nonmedical purposes.

GAO Comments

Our December 1986 report cited the need for clarification of home health coverage criteria for intermittent care, homebound status, and use of home health aides such as that contained in the three proposals. We stated that inconsistent interpretations of the criteria can result in unequal coverage of home health services for Medicare beneficiaries.

None of the legislative proposals would expand the basic Medicare benefit from a short-term, post-acute care benefit to one that would meet the home health needs of the chronically ill elderly. If the home care benefit were expanded to relieve the elderly of the high costs of long-term health care, adequate internal controls should be established to control utilization. Our prior work on home health care has shown that it is a difficult program to control and expanded coverage would likely increase utilization and costs. One way to control utilization might be to expand coverage but impose coinsurance to discourage overutilization.

Table 4:
Medicare Beneficiary's Annual Liability for Part B
Medical Expenses Covered by Medicare

	Medicare-approved charges			Physician and other charges in excess of approved charges
	Deductible	Deductible for blood	Coinsurance after deductible(s)	
Current Medicare law	$75	1st 3 Pints	20%	All
Medigap, maximum out-of-pocket costs	None[a]	None	None[b]	All
Bill #				
S. 1127	$75	1st 3 Pints	20%	All
H.R. 2470	$75	1st 3 Pints[c]	20%[c]	All
S. 592[d]	$75	1st 3 Pints	20%	All
H.R. 1245[d]	$75	1st 3 Pints	20%	All
S. 210	$75	1st 3 Pints	20%	All
S. 454	None	None	None	All
S. 754	$75	1st 3 Pints	20%	All
H.R. 65	None	None	None	All
H.R. 200	None	None	20%	None[e]
H.R. 784	$75	1st 3 Pints	None	All
H.R. 1182	$75	1st 3 Pints	20%	All
H.R. 1280[f]	$75	1st 3 Pints	20%	All
H.R. 1281[f]	$75	1st 3 Pints[c]	20%[c]	All
H.R. 1930	$75	1st 3 Pints	20%	All

[a]Medigap policies can have a maximum deductible of $200.

[b]Medigap policies can limit benefits to a maximum of $5,000.

[c]The deductible would be eliminated after the catastrophic limit is met.

[d]Administration bill.

[e]Physicians accepting reimbursement under this proposal may not charge the beneficiary additional amounts.

[f]Although we discuss the two bills separately, H.R. 1280 (which addresses part A) and H.R. 1281 (which addresses part B) comprise a legislative package for catastrophic protection. H.R. 1280 and H.R. 1281, when combined, are very similar to H.R. 2470.

MEDICARE PART B SERVICES

Definition

Medicare part B includes health care services rendered by physicians, nurse practitioners and other health care providers in private offices, hospitals, or other settings; therapies and surgeries provided in outpatient hospital departments or emergency rooms to individuals who enter and leave the hospital in the same day; services performed by laboratories, such as diagnostic tests and procedures; and other medical services and supplies.

Medicare Coverage

Part B is a voluntary insurance program for Medicare eligibles. For those who elect to enroll, it pays 80 percent of the approved charges after the beneficiary meets a $75 deductible, for most covered services.

Medicare-approved charges are based on what the law defines as "reasonable charges." The beneficiary is responsible for paying 20 percent of the Medicare-determined reasonable charge on claims where the physician or supplier has accepted assignment. For unassigned claims, the beneficiary is also liable for the difference between what the physician or supplier charges and what Medicare allows as the reasonable charge.

Approved charges for covered services are determined annually by Medicare carriers according to procedures prescribed by law. First, carriers determine the customary charge--the charge most frequently made--by providers for each separate service in the previous year. Then, the carrier determines the prevailing charge--the amount that is high enough to cover customary charges for three out of four bills--limited by an index relating physician fee increases to actual increases in the cost of maintaining their practices and to increases in general earnings. The approved charge will be the customary charge, prevailing charge, or actual charge, whichever is lowest.

Out-of-Pocket Expenses

According to the Secretary of Health and Human Services, the open-ended liability for unassigned claims for physician payment leaves beneficiaries open to risk for substantial out-of-pocket part B expenditures. The Secretary reported that in 1983, net beneficiary liabilities (not factoring in further reductions from Medigap insurance that covers coinsurance) amounted to $7.4 billion for part B services, or 33.5 percent of total part B expenditures. Moreover, part B expenses accounted for 72 percent of net beneficiary liabilities in 1983. Specifically, the part B deductible accounted for 14.3 percent and coinsurance for 35.5

percent of net beneficiary liabilities. In addition, charges above the approved Medicare rate accounted for over 22 percent of net beneficiary liabilities. These charges would generally not be covered by Medigap policies.

The Secretary also noted that Medicare provides very limited coverage for some part B services, notably outpatient mental health treatment. Beneficiaries requiring outpatient blood transfusions are also responsible for paying for the first three pints at an approximate cost of $50 to $150 per pint.

Legislative Proposals

Three bills (S. 454, H.R. 65, and H.R. 200) would eliminate the $75 deductible for part B services, including the blood deductible. Two of the three (S. 454 and H.R. 65) and H.R. 784 would eliminate the coinsurance for part B services. H.R. 200 would relieve the beneficiary of responsibility for charges in excess of Medicare-approved charges by prohibiting physicians who accept reimbursement under this proposal from charging the beneficiary additional amounts. H.R. 2470 would not alter the deductible or coinsurance for part B services, but would expand outpatient mental health benefits from $312.50 to $1,250 per year and cap the beneficiaries' part B liability at $1,043 per person, or $2,086 per elderly couple.

GAO Comments

Most of the catastrophic proposals would not change the deductibles and coinsurance for part B services, but would provide catastrophic protection against such costs through overall catastrophic limits. For most of the proposals, however, these limits would not protect beneficiaries from physician charges above the Medicare-approved rate on unassigned claims. According to HHS's Office of the Actuary, such charges accounted for over 30 percent of the out-of-pocket expenses of those Medicare beneficiaries with total out-of-pocket expenses of $2,000 to $4,999 in 1983. Medicare beneficiaries would continue to be liable for such out-of-pocket costs even when they meet the catastrophic limit in the proposed bills. One option for relieving the elderly of this burden would be to require physicians to accept assignment. Such a requirement currently exists under part B only for diagnostic laboratory expenses. Mandating assignment could, however, decrease the number of physicians willing to participate in the Medicare program.

Table 5:
Medicare Beneficiary's Liability for
Medical Expenses Not Covered by Medicare

	Prescription drugs	Hearing	Vision	Dental	Preventive lab tests
Current Medicare law	All	All	All	All	All
Medigap, maximum out-of-pocket costs	All	All	All	All	All
Bill #					
S. 1127	All	All	All	All	All
H.R. 2470	All	All	All	All	All
S. 592[a]	All	All	All	All	All
H.R. 1245[a]	All	All	All	All	All
S. 210	All	All	All	All	All
S. 454	All	None[b]	None[b]	None[b]	None[b]
S. 754	All	All	All	All	All
H.R. 65	None	None[b]	None[b]	None[b]	None[b]
H.R. 200	20%	20%	20%[c]	20%[c]	20%
H.R. 784	None[d]	All	All	All	All
H.R. 1182	All	All	All	All	All
H.R. 1280[f]	All	All	All	All	All
H.R. 1281[f]	All	All	All	All	All
H.R. 1930	$300[e]	All	All	All	All

[a]Administration bill.

[b]With limitations.

[c]Eyeglasses and preventive dental care are not covered until the earlier of January 1, 2000, or the first year total expenditures do not exceed 12 percent of the Gross National Product.

[d]For the treatment of chronic illness.

[e]Beneficiary would have to pay an indexed annual deductible of $300 and a $2 copayment per prescription.

[f]Although we discuss the two bills separately, H.R. 1280 (which addresses part A) and H.R. 1281 (which addresses part B) comprise a legislative package for catastrophic protection. H.R. 1280 and H.R. 1281, when combined, are very similar to H.R. 2470.

OTHER MEDICAL SERVICES NOT COVERED BY MEDICARE

Definitions

The following medical services are some of the major ones not covered by Medicare:

Routine physical examinations include periodic checkups, preventive laboratory tests, and immunizations.

Outpatient pharmaceutical drugs include drugs prescribed by physicians for acute and chronic health conditions, such as antibiotics, analgesics, anti-hypertensive drugs, and insulin.

Vision and hearing care includes examinations and fitting of eyeglasses, contact lenses, or hearing aids.

Dental care includes routine diagnostic and preventive services, such as checkups, X-rays, cleaning of teeth, and fillings.

Medicare Coverage

While Medicare part B does not cover the above services, there are some exceptions. For example, part B covers (1) 100 percent of the approved charge for pneumococcal vaccine (even if the $75 deductible has not been met), (2) 80 percent of the approved charge for hepatitis B vaccine for beneficiaries at high or intermediate risk of contracting the disease, (3) eyeglasses or corrective lenses prescribed after cataract surgery, and (4) dental care if it involves surgery of the jaw or related structures, setting fractures of the jaw or facial bones, or services that would be covered when provided by a physician.

Out-of-Pocket Expenses

Medicare beneficiaries are at risk for 100 percent of the charges for noncovered services. Using data from the 1980 National Medical Care Utilization and Expenditure Survey, researchers estimated that for the elderly who had out-of-pocket costs of from $1,001 to $2,000, prescription drugs accounted for 16.2 percent and dental care 12.6 percent of out-of-pocket costs.[17] According to the Congressional Budget Office, almost 5 million Medicare beneficiaries spend more than $400 annually on prescription drugs, and for this group, the average annual cost

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[17]Thomas Rice and Jon Gabel, "Protecting the Elderly Against High Health Care Costs," Health Affairs, Vol. 5, No. 3, Fall 1986, p. 16.

exceeds $900. Current retail prices of hearing aids range from $495 to $1,050 per unit, according to the four firms we contacted. In 1984, 14.5 percent of the elderly had hearing impairments, and of these, over half were hearing impaired in both ears.

Legislative Proposals

H.R. 65 would add coverage, with limitations, for prescription drugs, hearing aids, vision care, dental care, and preventive laboratory tests with no beneficiary cost sharing, and S. 454 would add coverage for all but prescription drugs, again without cost sharing. H.R. 200 would add coverage for all five services but would impose 20-percent coinsurance. H.R. 784 would add coverage of prescription drugs for treatment of chronic illnesses without beneficiary cost sharing, and H.R. 1930 would add a prescription drug benefit that would require the beneficiary to pay an indexed annual deductible of $300 and a $2 copayment per prescription. The nine remaining bills would not affect beneficiary out-of-pocket costs for the five noncovered services.

GAO Comments

Under the legislative proposals, Medicare beneficiaries would continue to be liable for out-of-pocket payments for services not currently covered by Medicare. And those payments would not count toward the catastrophic limits on out-of-pocket payments that would be established under most proposals. The House Committee on Energy and Commerce recently amended H.R. 2470 to provide protection against catastrophic outpatient prescription drug costs by limiting out-of-pocket costs to $500 a year. Beyond that point, Medicare would pay for all prescription drug costs. The Subcommittee on Health, House Committee on Ways and Means, also approved a prescription drug benefit that would pay 80 percent of outpatient drug costs exceeding $800 per year.

Table 6:
Catastrophic Limit on Medicare Beneficiary's Out-of-Pocket Costs for Medicare-Covered Services

	Dollar limit per calendar year
Current Medicare law	No provision in current law
Medigap, maximum out-of-pocket costs	No provision under Medigap requirements
Bill #	**First year catastrophic limit[a]**
S. 1127	$1,700
H.R. 2470	No limit on part A[c] $1,043 on part B
S. 592[b]	$2,000
H.R. 1245[b]	$2,000
S. 210	$2,000
S. 454	No limit[d]
S. 754	$1,800
H.R. 65	No limit[d]
H.R. 200	$500[e]
H.R. 784	No limit[d]
H.R. 1182	No limit[d]
H.R. 1280[f]	No limit[d]
H.R. 1281[f]	$1,000
H.R. 1930	$500

[a]Many of the bills provide for periodic increases to the catastrophic limit.

[b]Administration bills.

[c]H.R. 2470 establishes a catastrophic limit for part B only but would also reduce beneficiary part A expenses by eliminating coinsurance and reducing the deductibles to one per year.

[d]The bill has no catastrophic limit; however, the bill would decrease beneficiary expenses by reducing or eliminating coinsurance or deductibles.

[e]The bill states a $1,500 catastrophic limit. However, according to the bill's sponsor, this was a technical error and should be $500.

[f]Although we discuss the two bills separately, H.R. 1280 (which addresses part A) and H.R. 1281 (which addresses part B) comprise a legislative package for catastrophic protection. H.R. 1280 and H.R. 1281, when combined, are very similar to H.R. 2470.

CATASTROPHIC PROTECTION

Definition

Catastrophic protection sets a maximum amount beneficiaries would have to pay in a calendar year for covered medical services (excluding health insurance premiums). For certain acute illnesses and chronic conditions, the cumulative effect of deductibles, coinsurance, and services not covered by third-party payers can create severe financial hardship.

Medicare Coverage

Medicare has no limit on a beneficiary's out-of-pocket costs for Medicare-covered services.

Out-of-Pocket Expenses

Limited data are available on catastrophic out-of-pocket expenses. In terms of absolute dollars, married couples over age 65 incurred on average about $3,000 in out-of-pocket health care costs in 1986, according to a report prepared for AARP. In terms of health expenditures relative to family income, the report states that the percentage of income spent on out-of-pocket health expenditures increases from an average of about 4 percent for married couples 65 to 69 years old to over 30 percent for married couples 85 years old and over.

Legislative Proposals

H.R. 2470 places a $1,043 per beneficiary ($2,086 per couple) out-of-pocket cap on Medicare part B expenditures, and S. 1127 places a $1,700 per beneficiary ($3,400 per couple) cap on Medicare parts A and B expenditures. Seven other bills (S. 592, H.R. 1245, S. 210, S. 754, H.R. 200, H.R. 1281, and H.R. 1930) also establish catastrophic caps ranging from $500 to $2,000 for parts A and B covered services. H.R. 200, which proposes no deductibles, provides for a waiver of coinsurance for certain beneficiaries based on family income. Two of the proposals (S. 592 and S. 1127) would allow one expense--immunosuppressive drugs required to prevent rejection of transplanted organs--to be applied toward the catastrophic limit even though this expense is not covered by Medicare in the second year following transplant surgery.

GAO Comments

To the extent that the elderly incur high out-of-pocket costs for deductibles and coinsurance for part A and part B covered services, they would benefit from a fixed limit on out-of-pocket costs. According to a December 1986 article in Health Affairs, a disproportionately large percentage of families headed

by an individual over 65 years old incurred high out-of-pocket costs relative to income.[18] Catastrophic protection based on a fixed limit may not adequately alleviate the financial burden borne by the lower income elderly who spend a high percentage of their income on health expenses.

Moreover, over 81 percent of the expenses of the elderly with out-of-pocket costs in excess of $2,000 were for nursing home care. Most nursing home costs are not covered by Medicare because its coverage is directed at acute skilled care and it does not cover intermediate and custodial care. These costs, therefore, could not be applied toward the catastrophic cap. In addition, the burden of expenses for other noncovered services, including prescription drugs, preventive services, hearing aids, and dental care, would not be alleviated by the maximum limits established in the proposals.

Finally, the literature uses family income to analyze catastrophic expenses. Typically, resources that are used to pay for health care expenditures are pooled at the family level. The caps proposed in the bills, in contrast, are established on a per beneficiary basis. As a result, a husband and wife can each have out-of-pocket expenses approaching the catastrophic limit and not benefit from the proposed caps.

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[18]Leon Wyszewianski, "Families with Catastrophic Health Care Expenditures," Health Affairs, Vol. 21, No. 5, December 1986, p. 623.

FINANCING AND COSTS

The current Medicare part A and part B programs are financed separately. Part A is financed primarily through a compulsory payroll tax under the Federal Insurance Contributions Act. Under the act, equal payments are made by employers and employees. The self-employed also pay this tax. In addition, persons who are not entitled to part A benefits can pay a premium of $226 per month (in 1987) for hospital insurance. Monies are earmarked for the part A trust fund to pay benefits and administrative expenses. Part B, which is optional, is financed by premiums paid by or on behalf of those who elect coverage and general revenues. In 1987, the part B monthly premium is $17.90. Current law provides that premiums pay for 25 percent of benefits and administrative costs, and general revenues finance the remainder.

Several financing mechanisms were proposed in the bills we reviewed, including increased beneficiary part B premiums, increased income taxes for the elderly, increased payroll taxes, higher coinsurance charges, earmarked revenues from a tax on cigarettes, general revenues, or combinations of these. The self-funding financing mechanisms established in the House and Senate bills and in the administration bills are intended to keep the catastrophic Medicare insurance benefits budget neutral. Both S. 1127 and H.R. 2470 would raise part B premiums and would levy supplemental income-related premiums on the taxpaying elderly. (About 40 percent of the elderly now pay taxes.) In contrast, the administration bills finance the costs of catastrophic insurance exclusively through flat increases in part B premiums.

S. 1127 would impose a surtax on Medicare beneficiaries with income tax liability exceeding $150. The maximum surtax would be $800 for an elderly couple in 1988, rising to $1,000 by 1992. The Senate bill would also raise part B premiums by $4 per month in 1988.

H.R. 2470 would impose income-related supplemental premiums ranging from $10 to $580 per beneficiary, rather than per couple, in 1988. The maximum supplemental premium would increase to $930 per beneficiary, or $1,916 per couple, by 1992. Part B premiums would be raised $1 per month in 1990 followed by two $1.50 per month increases in 1991 and 1992.

The Congressional Budget Office projected additional Medicare benefit costs for the House, Senate, and administration bills as shown in table 7. (The Budget Office did not estimate the costs for the other proposals.)

Table 7: Medicare Benefit Costs Under Selected Catastrophic Proposals (1988-92)
(Fiscal year outlays, in millions of dollars)

Proposal	1988	1989	1990	1991	1992	Total 1988-92
H.R. 2470						
benefit costs	1,060	4,020	5,950	7,150	8,405	26,585
S. 1127						
benefit costs	1,340	3,430	4,725	5,600	6,530	21,625
S. 592/H.R. 1245						
benefit costs[a]	1,400	2,380	2,755	3,065	3,405	13,005

Source: U.S. Congressional Budget Office.

[a]Additional costs for a provision that would permit enrollees to substitute copayment costs for the fourth quarter of the previous year were not estimated.

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